



2012 Camper Health

In order to be registered at Camp Keystone, it is necessary that this form be filled out for each camper and returned with your registration. The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival at camp.

Please print or type & use black or blue ink:

Camper Name _____ Phone (____) _____
Last First Middle Initial

Birthdate _____ Age as of June 2012 _____ Sex _____ Grade as of Sept. '12 _____ Email Address _____

Home Address _____
Number/Street City State Zip

Mother's Name _____ Father's Name _____

Mother's Home Phone (____) _____ Father's Home Phone (____) _____

Mother's Work Phone (____) _____ Father's Work Phone (____) _____

Mother's Cell Phone (____) _____ Father's Cell Phone (____) _____

Mother's Occupation _____ Father's Occupation _____

If not available in an emergency, please notify _____

Relationship _____ Home Phone (____) _____

Work Phone (____) _____ Cell/Pager (____) _____

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes ___ No ___ Name of Insured _____

Carrier or Plan name _____ Group # _____

Carrier Address _____

Relationship to Participant _____ Policyholder insurance ID number _____

Medical Information

Has/does the participant:

General Questions	
Had any recent injury/illness/infectious disease?	___ Yes ___ No
Have a chronic or recurring illness/condition?	___ Yes ___ No
Have frequent headaches?	___ Yes ___ No
Ever had a head injury?	___ Yes ___ No
Wear glasses, contacts or protective eyewear?	___ Yes ___ No
Ever had frequent ear infections?	___ Yes ___ No
Ever passed out during or after exercise?	___ Yes ___ No
Ever had seizures?	___ Yes ___ No
Ever had chest pains?	___ Yes ___ No
Ever had back problems?	___ Yes ___ No

General Questions (cont.)	
Ever had problems with joints (knees, ankles)?	___ Yes ___ No
Have an orthodontic appliance being brought to camp?	___ Yes ___ No
Have any skin problems (itching, rash)?	___ Yes ___ No
Have diabetes?	___ Yes ___ No
Have asthma?	___ Yes ___ No
Had mononucleosis in the past 12 months?	___ Yes ___ No
Have problems with diarrhea/constipation?	___ Yes ___ No
If female, have an abnormal menstrual history?	___ Yes ___ No
Ever had emotional difficulties for which professional help was sought?	___ Yes ___ No

Please explain any "yes" answers from above. _____

Please assess your child's swimming ability: Non Swimmer _____ Beginner _____ Advanced Beginner _____ Intermediate _____

Advanced Intermediate _____ Proficient _____

Over

Does your child have any known allergies of food, medication, animals, bees, environmental? If yes, please state specific allergen and reaction.

What action should be taken? _____

Does your child have any activity restrictions? (If yes, please explain) _____

Has camper suffered a recent accident, illness, undergone any surgery, or have any specific physical limitations which would prevent him/her from participation in sports or physical activity? If so, please describe. _____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp and the counselors should be aware. _____

Name of family physician _____ Phone (____) _____

Address _____ Fax (____) _____

Immunizations

Please give all dates of immunizations, or attach a copy of your child's immunization card.

	1st - Date	2nd - Date	3rd - Date	4th - Date	5th - Date	6th - Date
Polio						
DTP						
MMR						
HIB/Meningitis						
Hepatitis B						
Varicella						

TB Skin Test: Date of last test _____ Result: Positive _____ Negative _____ Date of last Tetanus shot _____

Medications Being Taken

Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the name of the child, the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

____ This person takes NO medications on a routine basis. OR ____ This person takes medication as follows:

Medication #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Medication #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Parent's Consent For Treatment of a Minor

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to Camp Keystone to provide routine health care, administer prescribed medications, and seek emergency treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to Camp Keystone to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Keystone to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent or guardian or adult camper/staffer _____ Date _____